DTB time: group 1 (≤90 minutes, n=564) and group 2 (>90 minutes, n=274), and were evaluated the outcomes. Outcome measures included in-hospital complications (all-cause death, recurrent myocardial infarction, stroke, major bleeding or access site complications that needed treatment) and major adverse cardiovascular events (MACE: all-cause death, target vessel revascularization, recurrent myocardial infarction, admission of heart failure) at 3 years.

RESULTS Mean follow up period was 1211 ± 750 days. In-hospital complication rate was 7.8%in group 1, and 13.5% in group 2 at initial hospitalization (P=0.012). Kaplan-Meier survival curves showed that freedom from MACE was 69.4% in group 1 and 61.9% in group 2 at 3 years (P=0.077).

CONCLUSION Shorter door-to-balloon time was associated with less in-hospital complications in patients with STEMI although it did not reduce long-term MACE.

OTHER PHARMACOLOGIC AGENTS (TCTAP A-093, TCTAP A-095 TO TCTAP A-096)

TCTAP A-093

Determinants of Self-Discontinuation of Secondary Prevention Medications by Coronary Heart Disease Outpatients: Focus on the Role of Erectile Dysfunction

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BACKGROUND Despite the significant benefit of evidence-based therapy in reducing the cardiovascular outcomes among ischemic heart disease patients, many discontinue certain medications (Mx) selectively.

METHODS This is a cross-sectional study included 187 non diabetic patients with documented coronary heart disease. The interview took place in the cardiology clinic of Penang General Hospital in Northern Malaysia using a comprehensive medication review form to detect Mx stopped by the patient, along with exploring the potential reasons. Erectile dysfunction or ED (predictor of interest) was assessed using the Malaysian version of the abridged International Index of the Erectile Function (5-IIEF). In addition to sociodemographic factors, knowledge about Mx names, errors in taking the prescribed regimen, experienced adverse drug events (ADE), and use of anti-impotence Mx data were obtained from the patient. Binary logistic regression was employed to identify the relationships with Mx discontinuation (outcome).

RESULTS Forty-seven patients (25.1 %) had a history of discontinuing at least one Mx without consulting their prescriber. Aspirin was stopped by 14 (7.6 %) patients, while 12 (6.4 %) and 15 (8 %) patients had a history of discontinuing beta blocker sand statins, respectively. Two patients declared induced-ED as reason for Mx discontinuation. Among many others, inability to tolerate the ADE was the commonest (7.5 %). However, ED was mentioned as ADE by 27 (14.4%) patients. After controlling of sociodemographic factors; having non-CVD comorbidities [OR = 0.313 (0.212 - 0.810)], wrongly taking the regimen [OR = 3.19 (1.251 - 8.73)], and lower erectile functioning [p = 0.034, OR = 0.880 (0.781 - 0.990)] were the predictors significantly associated with Mx discontinuation.

CONCLUSION Although many patients did not admit ED as cause for Mx discontinuation, the majority had related it to the ADE. In addition to the need for enhancing patients' knowledge to accurately intake of the prescribed doses, it is required to diagnose and consult about ED related complaints in order to reduce the risk for personal discontinuation of vital secondary prevention therapy.

TCTAP A-095

Impact of Proton Pump Inhibitor on One-Year Clinical Outcomes in Patients Underwent Percutaneous Coronary Intervention According to Dual Versus Triple Antiplatelet Agents

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BACKGROUND It is controversial that proton pump inhibitor (PPI) might affect clopidogrel platelet response and can be associated with major adverse cardiovascular events (MACEs) in patients (pts) undergoing percutaneous coronary intervention (PCI). Particularly impact of PPI on pts with triple antiplatelets (TAT) following PCI is largely unknown.

METHODS A total 3747 patients (pts) undergoing PCI from Oct 2004 to Apr 2013 from prospective PCI registry were investigated. Exclusion criteria were age of more than 80 years, cardiogenic shock, chronic kidney disease (creatinine level≥2.0 or dialysis), in-hospital major bleeding requiring transfusion (major hematoma or retroperitoneal bleeding, gastro-intestinal bleeding), in-hospital death, and clinical follow-up loss less than 1-year after PCI. The pts were classified into dual antiplatelet therapy (DAT; aspirin+clopidogrel) and TAT (DAT+cilostazol) according to discharge medication. Finally, 2209 pts was enrolled in the DAT group and 697 pts in the TAT group. Major clinical outcomes at one year were compared between the two groups.

RESULTS At baseline, age, gender, diabetes, hypertension, dyslipidemia, cerebrovascular accident, and current smoking were balanced between PPI user and non-PPI user group in both DAT and TAT. Not only in DAT group but also in TAT group, there was no significant differences in clinical outcomes including total death, cardiac death, myocardial infarction, revascularization, all major adverse cardiovascular event (MACE), target lesion revascularization (TLR)-MACE, target vessel revascularization (TVR)-MACE, and stent thrombosis between PPI user and non-PPI user (Table).

CONCLUSION In our study, chronic PPI use was not associated with adverse cardiovascular outcomes up to 1-year in Korean pts undergoing PCI regardless of DAT and TAT.

Table. Association with PPI use and clinical outcomes according to DAT and TAT

One-year Clinical Outcomes	Dual antiplatelet agents (n=2209)			Triple antiplatelet agent (n=697)		
	PPI User (n=258)	Non-PPI User (n=1951)	p-value*	PPI User (n=69)	Non-PPI User (n=628)	p-value*
Total death, n (%)	5 (1.9)	21 (1.1)	0.228	2 (2.9)	7 (1.1)	0.213
Cardiac death, n (%)	2 (0.8)	11 (0.6)	0.677	0 (0)	6 (1.0)	0.415
Myocardial infarction, n (%)	4 (1.6)	23 (1.2)	0.610	0 (0)	17 (2.7)	0.166
Revascularization, n (%)	20 (7.8)	157 (8.0)	0.870	7 (10.1)	72 (11.5)	0.743
ALL-MACE, n (%)	26 (10.1)	177 (9.1)	0.599	9 (13.0)	79 (12.6)	0.912
TLR-MACE, n (%)	16 (6.2)	96 (4.9)	0.378	4 (5.8)	39 (6.2)	0.892
TVR-MACE, n (%)	23 (8.9)	131 (6.7)	0.192	6 (8.7)	57 (9.1)	0.917
Stent thrombosis, n (%)	2 (0.8)	16 (0.8)	0.940	1 (1.4)	12 (1.9)	0.788

* $\chi 2$ test
** DAT; dual antiplatelets, TAT; triple antiplatelets, PPI; proton pump inhibitor, TLR; target lesion revascularization, TVR; target vessel revascularization, MACE; major adverse cardiovascular events

TCTAP A-096

The Effect of Atorvastatin on Inflammatory Response in Patients with ST Segment Elevation Myocardial Infarction Post Primary Percutaneous Coronary Intervention

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BACKGROUND Myocardial necrosis triggers complement activation and neutrophyl adhesion which is mediated by Intercellular Adhesion Molecule (ICAM). Results from ARMYDTCTAP A-CAMS, showed that Atorvastatin continuous treatment reduced ICAM value in patients with stable angina pectoris. To date, there is no study yet which investigates the effect of acute Atorvastatin 80mg treatment in patients with ST Segment Elevation Myocardial Infarction (STEMI) post Primary Percutaneous Coronary Intervention (PPCI).